March 30, 2000

Jennifer Ryan, Senior CHIP Analyst
Health Care Financing Administration
7500 Security Boulevard
Mail Stop: S2-01-13
Baltimore, MD 21244

Dear Ms. Ryan,

Montana is pleased to submit to the Health Care Financing Administration our "State Evaluation of the Children's Health Insurance Program". We would especially like to thank the HCFA and National Academy for State Health Policy (NASHP) staff for their assistance on this project.

We are submitting both an electronic and a printed copy of this report to you and to Karen Shields at the HCFA Region VII Office. An electronic copy is being sent to Cynthia Pernice at the NASHP. These copies each include one attachment (Addendum to Table 3.1.1).

Questions about this Evaluation document can be directed to Jackie Forba, CHIP Program Officer at the Department of Public Health and Human Services. She can be reached by telephone at (406) 444-5288, by fax at (406) 444-4533 or by e-mail at jforba@state.mt.us.

Sincerely,

Laurie Ekanger
Director
Department of Public Health and Human Services

Enclosure

cc: Karen Shields – Region VII
Nancy Ellery

Montana CHIP

Children's Health Insurance Plan

State Evaluation of the Children's Health Insurance Program FFY 98 - 99

March 2000

MONTANA

Department of Public Health & Human Services

"How has health care for your children changed since they have been insured under the Children's Health Insurance Plan?"

- Question to CHIP Pilot families
CHIP Survey, Fall 1999

For the first time in a long time, I am able to get the boys yearly check-ups and sports physicals and not have to worry about how to pay for it. That is peace of mind, for a change.

This insurance has brought a lot of help, due to the fact the children have coverage. My responsibilities as a mom are so numerous – but to worry your kids can hurt themselves and I can't pay is too much.

My children's physical for sports and eyeglasses have been covered; definitely a help!

They are a lot healthier. I also am not embarrassed to take them to the Dr.. People are a lot nicer to us.

Chip has been a life saver.

Thank you.

I never denied my children medical treatment in the past, but now I don't worry about bills racking up or avoiding the medical receptionist's eyes!

Peace of mind for us and the no fee prescription plan; low fee doctor visits have made health care concerns less stressful. For us, as parents, but also for our children who know how hard pressed for money we are!

We have not needed to go to the doctor in the past year, but peace of mind is priceless.

Able to go to a doctor and get prescription medications. Went without before.

We never denied our children health care while they were insured. Having this health care though has taken a tremendous amount of stress off our minds and finances.

She is healthy.

My children are guaranteed health care off the reservation, and are not limited to the care they receive. I can rest assured the bill will be paid promptly and I won't be harassed.

I don't wait as long to take them to the doctor.

I don't play doctor anymore, to decide if my children can manage without a doctor or medicine.

It has provided my two children that became ineligible for Medicaid, health coverage on an ongoing and continuous basis.

We no longer feel stress about getting in debt due to health issues. My husband doesn't ask me anymore, "Can we afford it?" if I suspect my child has an ear infection or strep, etc. My youngest daughter needs speech therapy 2x week and just had surgery on her eye. I would like to think we could've provided that even if we didn't have insurance, but I'm not so sure. I feel confident they can get the care they need.

My children no longer suffer at home.

There isn't a worry for how to pay the bill.

Ear infections don't go on and on. My kids get checked right away and I am given preventative information right away.

I no longer have to balance my debts against a trip to the emergency room. It's given me peace of mind.

We are able to get help for our son. He is ADD and before we had insurance for him, he didn't always have his medicine.

They don't have to suffer any more when they are sick.

FRAMEWORK FOR STATE EVALUATION OF CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

State/Territory: Montana

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

_____

(Signature of Agency Head)
Laurie Ekanger, Director, Department of Public Health and Human Services

Date: 3-30-2000

Reporting Period: FY 1998, 1999

Contact Person/Title: Jackie Forba, CHIP Program Officer
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SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

Background Information for Montana's state-designed CHIP Program:

- Montana's State Plan was approved by HCFA on September 11, 1998.

- In FFY 1998 there was a half time FTE who worked on the development of the CHIP Program for Montana. No children were served during FFY 1998.

- We started the CHIP Pilot with a $210,000 intergovernmental transfer from the Office of Commissioner of Insurance. This amount of funding enabled us to provide health coverage to 1,019 children during the Pilot. Children began to receive health coverage benefits from the BlueCHIP program of Blue Cross Blue Shield effective January 1, 1999.

- In FFY 1999 there were one and a half FTE staffing our CHIP program. Their focus was the development and implementation of the program. The activities during this period included doing presentations about CHIP to community organizations and the general public, writing legislation, formulating the state plan, writing the state rules for the administration of the program, developing and negotiating the contract with our insurance partner, and designing the interim enrollment data base.

- In April 1999 the Montana Legislature appropriated the state match to be funded by a portion of Montana's share of the multi-state Tobacco Settlement.

- A more comprehensive data system that interfaces with other eligibility systems used by DPHHS was implemented in mid FFY 2000 and is undergoing final refinement and enhancements at this time.

- Phase II of the CHIP Program began October 1, 1999 (FFY 2000) and Montana's federal allotment and state match will allow us to insure 10,000 children. On March 1, 2000, after five months of operation, 3,888 children (38% of our goal) are enrolled and receiving health coverage through the CHIP program.

1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

1.1.1 What are the data source(s) and methodology used to make this estimate?

1.1.2 What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

The estimated baseline number of uncovered low-income children is listed in the table below. This data is the same estimated baseline that was submitted to HCFA in the 1998 annual report.

Montana has little data on the insurance status of its children. The only information available to us when we submitted our State Plan in 1998 was from the US Census Bureau. We cannot independently validate the census estimates. We provided these preliminary estimates in our State Plan at HCFA's request. We were unable to present data broken out by race, ethnicity, or geographic location.

Category	No. Children per Census Data CY 97	No. Estimated Uninsured CY 97
100% FPL		
Age Under 5	13,509	3,148
Age 5-11	18,667	4,349
Age 12-17	14,847	3,459
Age 18	3,538	925
Total 100%	**50,561**	**11,881**
150% FPL		
Age Under 5	21,295	3,769
Age 5-11	31,106	5,505
Age 12-17	24,712	4,373
Age 18	5,234	1,039
Total 150%	**82,347**	**14,686**
200% FPL		
Age Under 5	29,956	4,742
Age 5-11	44,921	7,111
Age 12-17	35,328	5,592
Age 18	6,701	1,190
Total 200%	**116,906**	**18,635**
All Incomes		
Age Under 5	55,660	5,598
Age 5-11	90,359	9,614
Age 12-17	86,732	10,176

Age 18	12,252	1,612
Total All Incomes	**245,003**	**27,000**

Data is cumulative for each age group and total. A September 1997 US Census Bureau document estimates the number of children who are uninsured at 23.3% of those 18 and under below the poverty level. Children on Medicaid are counted as insured. This is a national statistic that does not reflect individual state experiences. Each state has different eligibility requirements that are based on poverty levels. Older children were less likely to have health care coverage than younger children. 13.8% of children under 6, 14.6% of children 6-11, and 16.1% of children 12-17 were estimated to be uninsured.

Further estimates are based on US Census Bureau reports on Low Income Uninsured Children by State. In Montana, the number and percent of children under 19 years of age, at or below 200% of poverty, for 1994, 1995, and 1996 is 120,000 children or 48.1% of the population under 19 years of age. Those estimated to be without insurance were 19,000 or 7.9% of the population under age 19. This is 15.83% (19,000/120,000) of those at or below 200% of poverty. The Children's Defense Fund estimates the number of children in Montana who are 18 years of age or younger and without health insurance to be 27,000 or 10.7% of the population of that age group.

An independent telephone survey was conducted in April and May 1999 to determine whether there were children in the family and whether they had creditable health insurance coverage. Data was collected from 404 Montana residents who provided information on 1,542 persons, including themselves, who lived in the family household.

- Eighty-seven percent of the respondents indicated that they or other household members were covered by health insurance.
- Two-thirds of those without health coverage indicated that they or their family members have been without coverage for more than one year, while approximately fifteen percent have never had health insurance.
- The primary reason why respondents and family members did not have health insurance was because they could not afford the health insurance premium.
- Twenty-five percent of the respondents were below 150% of FPL.

Using the same questions on annual surveys in the future will allow us to compare the results with the baseline data and measure our progress.

1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

1.2.1 What are the data source(s) and methodology used to make this estimate?

1.2.2 What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Montana's Pilot CHIP program began to enroll eligible children and provide health coverage in January 1999. From January 1 through September 30, 1999 (nine months) the CHIP Pilot provided health coverage for a total of 1,019 children. (The source for the enrollment data was our CHIP database system and we have confidence in the reliability of this data.) These 1,019 children were previously uninsured. Thus the percentage of uninsured children under 150% FPL decreased by approximately 7%. No substantial outreach efforts were conducted in this time period and the number of children enrolled in Medicaid remained static.

1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?

Please complete Table 1.3 to summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List the State's strategic objectives for the CHIP program, as specified in the State Plan.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as possible concerning your findings to date. If performance goals have not been met, indicate the barriers or constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
Decrease the proportion of children in Montana who are uninsured and reduce financial barriers to affordable health care coverage	Decrease the proportion of children $\leq$ 150% FPL who are uninsured	Data Sources: Current Population Survey Methodology: 1994, 1995 and 1996 merged data set (baseline) comparison with FFY 1999 data Numerator: Number of children $\leq$ 150% FPL who were uninsured Denominator: Number of children $\leq$ 150% FPL Progress Summary: As of September 30, 1999, the program has reduced the percentage of uninsured children by 7%. Note: See attached narrative for more details
OBJECTIVES RELATED TO CHIP ENROLLMENT		
Enroll eligible children in the CHIP program	Enroll 1, 000 children who are under 150% FPL in the CHIP program by September 30, 1999	Data Sources: Internal CHIP data system Methodology: Number of enrolled children reported by the system through September 30, 1999

Table 1.3		
		Progress Summary: September 30, 1999, 1,019 children had been enrolled in CHIP since January 1, 1999 (9 months) Note: See attached narrative for more details
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
Increase the enrollment of currently eligible, but not participating, children in the Medicaid program	Ensure that 50% of children referred from CHIP to Medicaid enroll in Medicaid	Data Sources: Internal eligibility data, Medicaid enrollment data Methodology: Record match between CHIP eligibility data and Medicaid enrollment data performed Progress Summary: September 30, 1999, Not available - automated tracking system not Implemented in this time period. Note: See attached narrative for more details
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
Improve the health status of children covered by the CHIP program with a focus on preventive and early primary treatment		Data Sources: HEDIS data gathered by insurance plans Methodology: DPHHS to review HEDIS data for enrollees Numerator: Number of children with immunization and well-child care Denominator: Number of CHIP enrollees Progress Summary: Not available – QA system dependent upon one year (CY 1999) of data- not available at this time.

Table 1.3		
		Note: See attached narrative for more details
OTHER OBJECTIVES		
Coordinate and consolidate with other health care programs providing services to children to create a seamless health care delivery system for low-income children	Enroll a minimum of 50% of children on the waiting list for the Caring Program for Children into CHIP by December 1, 1999	Data Sources: Caring Program data system Methodology: Compare number of children of Caring Program waiting list in December 1998 with number on September 30, 1999. Numerator: Number of children who had been on the Caring Program waiting list who enrolled in CHIP during FFY 1999 Denominator: Total number of children on the Caring Program waiting list Progress Summary: There were 506 children on the Caring Progam waiting list in December 1998 and 204 (40%) of them enrolled in CHIP in FFY 1999. Note: See attached narrative for more details
	Coordinate with the Title V Children with Special Health Care Needs (CSHCN) and the Mental Health Access Program (MHAP) to ensure that children who need care beyond what is offered	Data Sources: Internal CHIP data system Methodology: Review of referral data to CSHCN and MHAP programs Numerator: Number of children referred to CSHCN and MHAP Denominator: Number of children needing care from CSHCN and MHAP

Table 1.3		
	under CHIP are referred to these programs	Progress Summary: CHIP outreach was targeted to children in MHAP and 65 children (6.4% of total) were enrolled in both programs. Care coordination meetings were held between CHIP and CSHCN on individual high need children. Referral tracking system non-existent during Chip Pilot. Note: See attached narrative for more details
Prevent "crowd out" of employer coverage	Maintain proportion of children $\leq$ 150% FPL who are covered under and employer-based plan taking into account decreases due to increasing health care costs or a downturn in the economy	Data Sources: Current Population Survey Methodology: 1994, 1995 and 1996 merged data set (baseline) and 1999 data Numerator: Number of children who are insured $\leq$ 150% FPL who are insured through employer coverage Denominator: Number of children $\leq$ 150 %FPL Progress Summary: Our only source of information on this measure is the census data and there is not a breakdown between private and employer-based insurance coverage. There were no children in the CHIP Pilot who had insurance coverage in the 3 months prior to enrolling in CHIP. Note: See attached narrative for more details

Narrative - Actual Performance Comparison to Performance Goals

Decrease the proportion of children < 150% FPL who are uninsured
FFY 2000 -Performance goals under this objective will be measured based on the decrease in the number of children in families with incomes ≤150% of the federal poverty level who are uninsured compared with the number that were uninsured before the effective date of this state plan. Two different measures will be used to determine the number of uninsured children. First, baseline numbers of uninsured children will be calculated from a three-year average of the 1995, 1996, and 1997 March supplement to the Current Population Survey produced by the Bureau of the Census. New estimates of uninsured children will be calculated as more current data become available and will be used to compare trends from year to year.

Enrollees who leave CHIP before their twelve months of eligibility have expired and those who fail to re-enroll will be surveyed to learn why they are no longer enrolled in CHIP. Responses will be tracked and used to evaluate the extent that CHIP has reduced financial barriers to affordable health care coverage.

Enroll 1, 000 children who are under 150% FPL in the CHIP program by September 30, 1999
Performance goal was met and exceeded.

FFY 2000 – Because of additional state matching dollars, the goal will be to enroll and provide health coverage to 10,000 children by September 30, 2000.

Enroll a minimum of 50% of children on the waiting list for the Caring Program for Children into CHIP by December 1, 1999 (FFY 2000)

Forty percent of the children on the Caring Program waiting list became enrolled in the CHIP Pilot Program as a result of targeted outreach to these individuals.

FFY 2000 - Performance goals under this objective will be based on the enrollment of children previously on the waiting list for the Caring Program for Children. Coordination with the administrator of the Caring Program will provide information about numbers of children enrolled in CHIP who were previously on the waiting list for the Caring Program.

Ensure that 50% of children referred from CHIP to Medicaid enroll in Medicaid
If a family applying for CHIP was found to be potentially Medicaid, they were sent a Medicaid application and referred to their county Office of Public Assistance (OPA). The OPA office was also notified of this referral. There was no automated tracking system of referrals available during the CHIP Pilot.

FFY 2000 - Clients who enroll in CHIP will be tracked in an eligibility system that interfaces with the Medicaid Management Information System allowing for coordination with Medicaid. The CHIP eligibility system will also perform Medicaid screening and allow the state to track the number of children who were referred to

Medicaid through the eligibility determination process. CHIP will query Medicaid enrollment data to learn how many children referred from CHIP to Medicaid have enrolled. Follow-up will be conducted with families to encourage application for Medicaid. When families check the box indicating they do not want to be screened for Medicaid, CHIP will contact them 2 weeks after the denial letter to stress the "importance of applying for Medicaid." Workers will also explicitly explain in readily understandable terms what benefits and services are offered under Medicaid.

Montana will have data about the level of Medicaid enrollment for children referred from the CHIP eligibility staff. CHIP has defined the information to be obtained in report format from the new eligibility and enrollment system and we expect to begin receiving the report within six months.

Coordinate with the Title V Children with Special Health Care Needs and the Mental Health Access programs to ensure that children who need care beyond what is offered under CHIP are referred to these programs.
See progress summary on Table 1.3.

FFY 2000 - Performance goals under this objective will be based on the enrollment of children receiving care through the Title V Children with Special Health Care Needs and the Mental Health Services Plan. CHIP will query MMIS to find whether children are enrolled in both programs. Follow-up will be conducted with these programs to determine if the children referred by the CHIP program are receiving services from these programs.

Maintain proportion of children < 150% FPL who are covered under and employer-based plan taking into account decreases due to increasing health care costs or a downturn in the economy.
See progress summary on Table 1.3.

FFY 2000 – The proportion of children covered under an employer-based plan will be evaluated, and analysis will be conducted to test for evidence of "crowd-out". The baseline for comparison will be obtained from a 3-year average of the 1995, 1996 and 1997 March supplement to the Current Population Survey. In addition, the eligibility determination process will include questions relating to past employer-based insurance coverage. This will allow the state to track the number of children who have access to employment-based coverage and to ensure that children enrolling in CHIP are uninsured and not dropping their employment-based coverage to enroll in CHIP.

SECTION 2. BACKGROUND

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

___ Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program:
_____

Date enrollment began (i.e., when children first became eligible to receive services):
_____

_X_ Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)

Name of program: Children's Health Insurance Plan

Date enrollment and services began: January 1, 1999

___ Other - Family Coverage

Name of program:
_____

Date enrollment began (i.e., when children first became eligible to receive services):
_____

___ Other - Employer-sponsored Insurance Coverage

Name of program:
_____

Date enrollment began (i.e., when children first became eligible to receive services):
_____

___ Other - Wraparound Benefit Package

Name of program:

_____

Date enrollment began (i.e., when children first became eligible to receive services):

_____

___ Other (specify)

Name of program:

_____

Date enrollment began (i.e., when children first became eligible to receive services):

_____

2.1.2 **If State offers family coverage:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

Not applicable

2.1.3 **If State has a buy-in program for employer-sponsored insurance:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

Not applicable

2.2 What environmental factors in your State affect your CHIP program? (Section 2108(b)(1)(E))

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

We designed the CHIP program for uninsured children up to 150% of FPL so that we could provide health coverage to children in families whose income exceeds the eligibility requirements for family related Medicaid programs. Those eligibility requirements are:

- 133% FPL for Poverty Child and Poverty Pregnancy (ages 0-5)
- 100% FPL for Poverty Six (ages 6-16)
- 40.5% FPL for Family-related Medicaid (ages 17-18)

2.2.2 Were any of the preexisting programs "State-only" and if so what has happened to that program?

_X No pre-existing programs were "State-only"

___ One or more pre-existing programs were "State only" ! Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into CHIP?

2.2.3 Describe changes and trends in the State since implementation of your Title XXI program that "affect the provision of accessible, affordable, quality health insurance and healthcare for children." (Section 2108(b)(1)(E))

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

___ Changes to the Medicaid program

Not Applicable

___ Presumptive eligibility for children
___ Coverage of Supplemental Security Income (SSI) children
___ Provision of continuous coverage (specify # of months)
___ Elimination of assets tests
___ Elimination of face-to-face eligibility interviews
___ Easing of documentation requirements

__ Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify)

_X_ Changes in the private insurance market that could affect affordability of or accessibility to private health insurance

_X_ Health insurance premium rate increases - minimal
_ _ Legal or regulatory changes related to insurance
___ Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)
___ Changes in employee cost-sharing for insurance
___ Availability of subsidies for adult coverage
___ Other (specify) _____

_X_ Changes in the delivery system accessibility to private health insurance

- _X_ Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity) – slow growth in penetration; still very low compared to other states
- ___ Changes in hospital marketplace (e.g., closure, conversion, merger)
- ___ Other (specify) _____

___ Development of new health care programs or services for targeted low-income children (specify)

_____

_X_ Changes in the demographic or socioeconomic context

- _X_ Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify) Despite an increase in Montana's population, there has been a 1.6% decline in the number of children 0-18 years of age from 1997 to 1999. (US Census Population Estimates, release date: 3-9-2000).
- _X_ Changes in economic circumstances, such as unemployment rate (specify) The unemployment rate remains relatively unchanged from 1997-1999 (1997 – 5.4;1998 – 5.6; 1999 -5.2).Montana's per capita income ranking remained unchanged (1997 & 1998 - 47th out of the 50 states).
- ___ Other (specify)
- ___ Other (specify) _____

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter "NA."

Table 3.1.1

	Medicaid CHIP Expansion Program	**State-designed CHIP Program**	**Other CHIP Program*** _____ _____ __
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))		State of Montana	
Age		0-18 years	
Income (define countable income)		≤ 150% FPL for adjusted gross income	
Resources (including any standards relating to spend downs and disposition of resources)		NA	
Residency requirements		U.S. citizen or qualified alien and Montana resident	
Disability status		NA	

Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))		Not covered by health insurance during 3 months prior to application (limited exceptions apply). Not eligible for Medicaid. Not eligible to receive health insurance benefits under Montana's state employee benefit plan.	
Other standards (identify and describe)		Not an inmate of a public institution.	

Definitions:

Age: The plan is available to children ages zero through eighteen. Coverage for a child will continue through the end of the month of the child's 19th birthday.

Income: Children from families whose adjusted gross income (as defined for federal income tax purposes) is at or below 150% of the federal poverty level are eligible. Earned (wages, tips, salaries, etc.) and unearned (child support, unemployment, etc.) income will be counted when determining adjusted gross income. Any income excluded by other federal statute will not be counted.

The applicant must provide verification of income, this could include wage or salary pay stubs, W-2 forms, the most recent income tax returns (state or federal), an employer's payroll records, or an employer's written statement of earnings.

For purposes of determining financial eligibility for CHIP, a family unit consists of:

1. The child for whom the family is applying
2. The natural or adoptive parents of the child
3. Spouses residing together
4. Siblings (natural, adoptive, half, or stepbrothers/sisters) from ages zero through eighteen, with the following exception: If a sibling is between ages nineteen through twenty-two and is attending an institute of higher learning, he or she may be counted in the family unit.

An emancipated minor who applies for CHIP is considered his or her own family (family of one).

Residency: U.S. Citizenship and Montana residency are required. A Montana resident is

anyone who declares him-or-herself to be living in the state, including migrant and other seasonal workers. The parent will be required to certify on the application that the child is a U.S. citizen or Qualified Alien and a Montana resident. Montana will follow federal guidelines in determining whether a child is a U.S. citizen or Qualified Alien and eligible for CHIP.

Disability Status: No child is denied eligibility based on disability status. If the child receives SSI and is eligible for Medicaid, the child will be denied coverage because of eligibility for Medicaid, not for disability status.

Access to or coverage under other health coverage: A child will be found ineligible when: 1) the child is covered under a group health plan or under health insurance coverage as defined in section 2791 of the Public Health Service Act; 2) the child is eligible for Medicaid; or 3) the child is eligible to receive health insurance benefits under Montana's state employee benefit plan;

Other standards: Usually a child will be ineligible for CHIP if the child has been covered under an individual or group health plan during the three months prior to application for CHIP. If, however, a parent who is providing the primary insurance is fired, laid off, can no longer work because of a disability, has an employer who no longer provides dependent health insurance coverage, has a lapse in insurance coverage because he or she obtains new employment, or if the parent dies, the three-month waiting period for the Children's Health Insurance Plan will not apply.

If a child becomes an inmate of a public institution, CHIP coverage will terminate.

3.1.2 How often is eligibility redetermined?

Table 3.1.2			
Redetermination	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Monthly			
Every six months			
Every twelve months		X	
Other (specify)			

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

___ Yes ° Which program(s)?

For how long?

_X_ No

Once a child has been accepted, he or she remains eligible for one year from the date of enrollment in CHIP unless the child moves from the state, is enrolled in Medicaid, is found to have other creditable coverage or the family notifies CHIP of information which would make the child ineligible (e.g. income changes).

3.1.4 Does the CHIP program provide retroactive eligibility?

___ Yes ° Which program(s)?

How many months look-back?

X_ No

3.1.5 Does the CHIP program have presumptive eligibility?

___ Yes ° Which program(s)?

Which populations?

Who determines?

X No

3.1.6 Do your Medicaid program and CHIP program have a joint application?

___ Yes ° Is the joint application used to determine eligibility for other State programs? If yes, specify.

X No

FFY 2000 - a joint application was implemented January 2000.

3.1.7 Evaluate the strengths and weaknesses of your eligibility determination process in increasing creditable health coverage among targeted low-income children

The Public Assistance Bureau of DPHHS was integral in the eligibility determination process for the CHIP Pilot. Their staff worked for three weeks reviewing applications and determining eligibility. Since the CHIP staff during FFY 1999 consisted of the Medicaid Bureau Chief (1/2 FTE) and 1 staff person, the eligibility determination process would have been much more difficult and protracted without the assistance of these dedicated, experienced Public Assistance workers.

In late FFY 1999 the CHIP program decided not to contract with an outside enrollment broker for FFY 2000 but to have the program perform its own in-house eligibility and enrollment functions. The cost-benefit analysis conducted on these two options supported this decision.

FFY 2000 – An Eligibility Supervisor and three Eligibility Specialists were hired and trained in the Fall of 1999. They provide high-quality eligibility and enrollment services with a primary focus on customer service and satisfaction.

CHIP applications are available to families at FQHCs, community health and county public health departments, IHS tribal sites, county offices of public assistance, WIC offices, many more community locations, and on the Internet. While many of these sites have personnel or advocates available to assist families in completing the application and locating proper documentation to submit with the application, the eligibility determination is not actually performed at these sites.

Completed applications are mailed to the CHIP state office, where the eligibility determination is performed. A family is notified of the status of an application within two weeks of receipt of the application by CHIP. Benefits begin on the first day of each month.

3.1.8 Evaluate the strengths and weaknesses of your eligibility redetermination process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

The redetermination process is identical to the initial eligibility determination process. (See response to Question 3.1.7)

3.2 What benefits do children receive and how is the delivery system structured? (Section 2108(b)(1)(B)(vi))

3.2.1 Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost sharing (if any), and benefit limits (if any).

Table 3.2.1 CHIP Program Type State-designed CHIP program			
Benefit	Is Service Covered? (**X** = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	X	$25; only for enrollees > 100% FPL	
Emergency hospital services	X	$5; only for enrollees > 100% FPL	
Outpatient hospital services	X	$5; only for enrollees >100% FPL	
Physician services	X	$3; only for enrollees > 100% FPL	
Clinic services	X	$3; only for enrollees > 100% FPL	
Prescription drugs	X	$5 for brand name drugs, $3 for generic drugs; only for enrollees > 100% FPL	
Over-the-counter medications			
Outpatient laboratory and radiology services	X	No co-pay	
Prenatal care	X	No co-pay	
Family planning services	X	No co-pay	
Inpatient mental health services	X	$25; only for enrollees > 100% FPL	≤ 21 days combined MH/SA benefits per benefit year; Partial hospitalization services may be exchanged for inpatient days at a rate of 1 inpatient day for 2 partial treatment days; Coordinated w/ Mental Health Access Plan (MHAP) benefits; No limits on inpatient benefits for children w/severe emotional disturbances * in the MHAP program.

Outpatient mental health services	X	$5; only for enrollees > 100% FPL	≤ 20 visits per year through CHIP; Coordinated w/ Mental Health Access Plan (MHAP) benefits; No limits on inpatient benefits for children w/ severe emotional disturbances * in the MHAP program.
Inpatient substance abuse treatment services	X	$25; only for enrollees > 100% FPL	Combined benefit for inpatient and outpatient treatment for alcoholism and drug addiction, excluding costs for medical detoxification**, subject to a minimum benefit of $6,000 in a 12-month period, until a lifetime inpatient maximum benefit of $12,000 is met, after which the annual benefit may be reduced to $2,000. Costs for medical detoxification treatment are paid the same as any other illness and are not subject to lifetime limits.
Residential substance abuse treatment services	X	$25; only for enrollees > 100% FPL	Refer to "Benefits Limits" for inpatient substance abuse services.
Outpatient substance abuse treatment services	X	$5; only for enrollees > 100% FPL	Refer to "Benefits Limits" for inpatient substance abuse services.
Durable medical equipment			
Disposable medical supplies			
Preventive dental services			
Restorative dental services			
Hearing screening	X		
Hearing aids			
Vision screening	X		

Corrective lenses (including eyeglasses)			
Developmental assessment			
Immunizations	X	No co-pay	
Well-baby visits	X	No co-pay	
Well-child visits	X	No co-pay	
Physical therapy			
Speech therapy			
Occupational therapy			
Physical rehabilitation services			
Podiatric services			
Chiropractic services			
Medical transportation			

Home health services			
Nursing facility			
ICF/MR			
Hospice care			
Private duty nursing			
Personal care services			
Habilitative services			
Case management/Care coordination			
Non-emergency transportation			
Interpreter services			
Other (Specify) Employment & athletic physical exams	X	$3; only for enrollees > 100% FPL	
Other (Specify)			
Other (Specify)			

** Costs for medical detoxification treatment are paid the same as any other illness and are not subject to the lifetime limits.

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

The following statements apply to all services covered in this section:

- There are no pre-existing condition limitations.
- Experimental procedures, custodial care, personal comfort/hygiene/convenience items which are not primarily medical in nature, whirlpools, organ and tissue transplants, TMJ treatment, treatment for obesity, acupuncture, biofeedback, chiropractic services, elective abortions, in vitro fertilization, gamete or zygote intrafallopian transfer, artificial insemination, reversal of voluntary sterilization, transsexual surgery, fertility enhancing treatment beyond diagnosis, cosmetic surgery, radial keratotomy, private duty nursing, treatment for which another coverage such as workers compensation is responsible, routine foot care, services for members confined in criminal justice institutions, and any treatment not medically necessary are not a covered benefit. These exclusions are in addition to exclusions noted in the individual coverage descriptions.
- A $1 million lifetime maximum benefit coverage per insured person per health plan applies.
- The total of the co-payments for the benefit year will not exceed $200 per year per family.

- Medically necessary benefits include the following: inpatient and outpatient hospital services, physician services, advanced practice registered nursing services, prescription drugs, laboratory and radiology services, mental health services, chemical dependency services, vision services, audiology services. Emergency services, including urgent care and emergency room screening to determine if a medical emergency exists, are available 24 hours per day, 7 days a week.

- Inpatient hospital services: Semi-private room; intensive and coronary care units; general nursing; drugs; oxygen; blood transfusions; laboratory; imaging services; physical, speech, occupational, heat, and inhalation therapy; operating, recovery, birthing and delivery rooms; routine and intensive nursery care for newborns; and other medically necessary services and supplies for treatment of injury or illness are covered.

Coverage of postpartum care for at least forty-eight hours for vaginal delivery and ninety-six hours for cesarean section is guaranteed.

Services for mental and chemical dependency disorders are outlined below.

Organ and tissue transplants are not covered.

- Outpatient hospital services: All services which are provided on an outpatient basis in a hospital (including but not limited to observation beds and partial hospitalization services) or ambulatory surgical center; chemotherapy; emergency room services for surgery, accident or medical emergency; and other services for diagnostic or outpatient treatment of a medical condition, accident, or illness are covered.

  Services for mental and chemical dependency disorders are described below.

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- Physician services: Office, clinic, home, outpatient surgical center and hospital treatment for a medical condition, accident, or illness by a physician.

  Well-child, well-baby, and immunization services as recommended by the American Academy of Pediatrics are covered.

  Routine physicals for sports, employment, or required by a government authority are covered.

  Professional services rendered by a physician, surgeon, or doctor of dental surgery for treatment of a fractured jaw or other accidental injury to sound natural teeth and gums are covered.

  Anesthesia services rendered by a physician-anesthesiologist (other than the attending physician or assistant) or by a nurse anesthetist are covered provided that surgical and/or hospital benefits are also covered. Hypnosis, local anesthesia (unless it is included as part of a global procedure charge), and consultations prior to surgery are not covered.

  Organ and tissue transplants are not covered.

- Clinic services (including health center services) and other ambulatory health care services: Coverage as described for other services.

- Prescription drugs: Coverage includes drugs prescribed by a practitioner acting within the scope of his or her practice.

Chemotherapy drugs approved for use in humans by the U.S. Food and Drug Administration, vaccines, and drugs needed after an organ or tissue transplant are covered.

Plans may use the Medicaid formulary.

Diabetic supplies including insulin, test tape, syringes, needles, and lancets are covered as prescription drugs.

Food supplements and vitamins (with the exception of prenatal vitamins), whether or not requiring a written prescription, are not covered.

- Outpatient laboratory and radiological services: Coverage includes imaging and laboratory services for diagnostic or therapeutic purposes due to accident, illness, or medical condition that are not described elsewhere in this section.

  X-ray, radium, and radioactive isotope therapy are covered.

- Prenatal care:
  Prenatal care is covered as described for other medical conditions in this section.

- Family planning services:
  Pre-pregnancy family planning services and contraceptives are covered.

  Medical or surgical treatment to reverse surgically induced infertility; fertility- enhancing procedures beyond diagnosis; and sex change operations are excluded.

- Inpatient mental health services:
  CHIP covers up to twenty-one days of combined mental health/chemical dependency benefits per benefit year. Partial hospitalization services may be exchanged for inpatient days at a rate of one inpatient day for two partial treatment days. A partial hospitalization program that is operated by a hospital must comply with the standards for a partial hospitalization program that are published by the American Association for Partial Hospitalization.

  CHIP enrollees who had mental health needs beyond the coverage provided by CHIP and who had been diagnosed as seriously emotionally disturbed were eligible for Montana's Mental Health Access Plan (MHAP). MHAP was a comprehensive managed care program that provided mental health care to Montana children who were seriously emotionally disturbed. MHAP had no coverage limits

beyond medical necessity. MHAP paid the mental health benefits for children enrolled in CHIP and MHAP. Effective July 1, 1999 Montana's mental health system changed from MHAP to the Mental Health Services Plan (MHSP), a fee for service plan administered by the Department of Health and Human Services (DPHHS).

FFY 2000 – Children enrolled in CHIP and MHSP have their mental health benefits paid by CHIP up to specified limits and then are supplemented by MHSP. CHIP enrollees with the following disorders are not subject to a limit on covered inpatient mental health benefits provided by CHIP: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, and autism.

- Outpatient mental health:
  Professional outpatient services up to a maximum of twenty visits per year will be paid through the insurance plan. Partial hospitalization services are paid as described above. Children who are enrolled in CHIP and MHSP and need services beyond those CHIP provides may obtain those services from MHSP.

  Outpatient mental health services are coordinated between CHIP and the Mental Health Services Plan (MHSP). CHIP enrollees who have mental health needs beyond the coverage provided by CHIP and who have been diagnosed as seriously emotionally disturbed are eligible for MHSP.

  FFY 2000 - CHIP enrollees with the following disorders are not subject to a limit on covered inpatient mental health benefits provided by CHIP: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, and autism.

- Inpatient and residential substance abuse treatment services:
  The combined benefit for inpatient and outpatient treatment for alcoholism and drug addiction, excluding costs for medical detoxification, is subject to a minimum benefit of $6000 in a 12-month period, until a lifetime impatient maximum benefit of $12,000 is met, after which the annual benefit may be reduced to $2,000. Costs for medical detoxification treatment are paid the same as any other illness and are not subject to the lifetime limits.

- Outpatient substance abuse treatment services:
  The combined benefit for inpatient and outpatient treatment for alcoholism and drug addiction, excluding costs for medical detoxification, is subject to a minimum benefit of $6000 in a 12-month

period, until a lifetime impatient maximum benefit of $12,000 is met, after which the annual benefit may be reduced to $2,000. Costs for medical detoxification treatment are paid the same as any other illness and are not subject to the lifetime limits.

- Hearing Screening:
  Hearing exams, including newborn hearing screens in a hospital or outpatient setting, are covered. Coverage includes assessment and diagnosis. Hearing aides are not covered.

- Preventive services include immunizations, well baby, well child and family planning visits. There are no co-pays for these services.

- The services available to children with special health care needs are the same as those available to all children enrolled in the CHIP program (refer to Table 3.2.1).

- Enabling services were not provided in FFY 1999.

FFY 2000 – The change in benefits from FFY 1999, as specified by Montana's 1999 legislature, are the loss of prescription benefits for birth control contraceptives and the addition of the following:

- *Dental services:*
  The State of Montana contracts directly with dentists who participate in CHIP; dental services are not part of the insurance benefit. Each child enrolled in CHIP has a $350 dental benefit per benefit year. A benefit year is October 1 through September 30. All services are included except: Maxillofacial surgeries and prosthetics, dental implants, surgical procedures, treatment of fractures and orthodontics. There are no co-payments for dental services.

- *Vision Services:*
  Each child enrolled in CHIP receives one vision exam and one pair of eyeglasses per benefit year (unless a child has a medical condition that requires more frequent prescriptions). A benefit year is October 1 through September 30. The insurance plan pays for the vision exam and dispensing fee for eyeglasses. Eyeglasses are paid for by the State under a volume-purchasing contract.

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

Table 3.2.3			
Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
A. Comprehensive risk managed care organizations (MCOs)		The CHIP Program paid a monthly capita-tion to the indemnity insur-ance plan.	
Statewide?	___ Yes ___ No	_X_ Yes ___ No	___ Yes ___ No
Mandatory enrollment?	___ Yes ___ No	_X_ Yes ___ No	___ Yes ___ No
Number of MCOs		1	
B. Primary care case management (PCCM) program			
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)			
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)			
E. Other (specify)			
F. Other (specify)			
G. Other (specify)			

FFY 2000 – Dental services and eyeglasses have been added as covered benefits and are paid on a fee-for-service basis by DPHHS.

3.3 How much does CHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/co-payments, or other out-of-pocket expenses paid by the

family.)

___ No, skip to section 3.4

_X_ Yes, check all that apply in Table 3.3.1

Table 3.3.1			
Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program
Premiums		NA	
Enrollment fee		$15 annually for families > 100% FPL	
Deductibles		NA	
Coinsurance/co-payments		**Co-payments Cap = $200 per family per year	
Other (specify) _____			

**See Table 3.2.1 for detailed information.

3.3.2 **If premiums are charged:** What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

Not Applicable

3.3.3 **If premiums are charged:** Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

___ Employer
___ Family
___ Absent parent
___ Private donations/sponsorship
___ Other (specify) _____

3.3.4 **If enrollment fee is charged:** What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

An annual enrollment fee of $15 per family per year is assessed for families living between 100% and 150% of poverty. No enrollment fee is assessed for families living at or below 100% of poverty.

<u>FFY 2000</u> – When Chip's eligibility and enrollment system has been enhanced to permit the program to exclude the enrollment for Native Americans, Montana will submit a State Plan Amendment excluding Native Americans from the cost-sharing provision.

3.3.5 **If deductibles are charged:** What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

Not Applicable

3.3.9 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

The insurance plan provides an Enrollee Handbook, which specifies the cost-sharing requirements and maximum, to all members upon enrollment in the CHIP Program. In addition, the enrollee's CHIP identification card indicates if co-payment is required.

Each Explanation of Benefits (EOB) indicates the total amount of co-payments made to date per individual as well as when the $200 per family maximum has been met. The EOB can then be used by the family to show any subsequent medical providers that they are no longer subject to the co-payment.

3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

_ __ Shoebox method (families save records documenting cumulative level of cost sharing)
_<u>X</u>_ Health plan administration (health plans track cumulative level of cost sharing)
___ Audit and reconciliation (State performs audit of utilization and cost sharing)
___ Other (specify)_____

3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

During the nine months of our CHIP Pilot in FFY 1999 there was only one family that hit the 5 percent cap.

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what

have you found?

Not applicable.

3.4 How do you reach and inform potential enrollees?

3.4.1 What client education and outreach approaches does your CHIP program use?

During the CHIP Pilot, direct mailings to targeted groups were done. Letters and applications were mailed to the following groups: families on the "Caring Program" waiting list, enrollees in the Mental Health Access Plan, Indian Health Service enrollees (non-Medicaid) and former TANF families who had their benefits discontinued within the previous 6 months. Approximately 5,000 applications were sent and 1,200 were returned.

FFY 2000 - DPHHS contracted with the Robert Wood Johnson Covering Kids grantee in Montana to perform outreach activities for CHIP, Medicaid, Mental Health Services Plan (MHSP), and Special Health Services. Covering Kids advocates are located in 13 Montana communities. The Covering Kids outreach contract is closely monitored by a member of the CHIP staff.

DPHHS contracted with 31 community-based organizations to perform outreach for Medicaid. DPHHS believes that communities are unique in their outreach needs and know what works best in their own communities.

The CHIP Outreach Coordinator manages the contracts with the community-based organizations, coordinates all outreach activities within the state, and plans outreach in Montana communities having no Covering Kids advocates or contracts with community-based organizations.

The CHIP outreach plan involves close coordination with Montana businesses and schools.

Table 3.4.1						
Approach	Medicaid CHIP Expansion		State-Designed CHIP Program (CHIP Pilot – limited enrollment, effective January – September 1999)		Other CHIP Program* _____ _	
	T = Yes	Rating (1-5)	**X** = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Billboards						
Brochures/flyers						
Direct mail by State/enrollment broker/administrative contractor			X	3		
Education sessions			X	2		
Home visits by State/enrollment broker/administrative contractor						
Hotline						
Incentives for education/outreach staff						
Incentives for enrollees						
Incentives for insurance agents						
Non-traditional hours for application intake						
Prime-time TV advertisements						
Public access cable TV						

Public transportation ads						
Radio/newspaper/TV advertisement and PSAs			X	4		
Signs/posters						
State/broker initiated phone calls						
Other (specify)						
Other (specify)						

3.4.2 Where does your CHIP program conduct client education and outreach?

Client education and outreach was not conducted at these locations during our CHIP Pilot.

<u>FFY 2000</u> - Client education and outreach efforts were initiated and include all the locations listed in 3.4.2. Some examples of other locations include Head Start, WIC Clinics, county Offices of Public Assistance, insurance agencies, university health services and graduate housing, attorneys' and legal service offices, USDA Farm Services agencies, Volunteer Income Tax Assistance (VITA) offices, income tax preparers and Food Pantries.

Table 3.4.2						
Setting	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* _____	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Battered women shelters						
Community sponsored events						
Beneficiary's home						
Day care centers						
Faith communities						
Fast food restaurants						
Grocery stores						
Homeless shelters						
Job training centers						
Laundromats						
Libraries						
Local/community health centers						
Point of service/provider locations						

Public meetings/health fairs						
Public housing						
Refugee resettlement programs						
Schools/adult education sites						
Senior centers						
Social service agency						
Workplace						
Other (specify)						
Other (specify)						

3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

Not applicable

3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

Not applicable

3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

Not applicable

3.5 What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

Table 3.5

Type of coordination	Medicaid*	Maternal and child health	Other (specify) Mental Health Access Plan	Others (specify) "Caring Program"; TANF; IHS
Administration	X			
Outreach			X	X
Eligibility determination	X			
Service delivery			X	

Procurement				
Contracting				
Data collection				
Quality assurance				
Other (specify)				
Other (specify)				

Coordination with other health programs in FFY 1999 include targeted outreach efforts (mailing information and CHIP applications) with clients of the Mental Health Access Plan, Caring Program, Indian Health Service (IHS) and Temporary Assistance for Needy Families (TANF).

Administration and eligibility determination coordination efforts took place between CHIP and the Medicaid Program. Montana ensured that Medicaid-eligible children were enrolled in Medicaid using the following protocols:

Families who gave permission to forward information to Medicaid

The CHIP program screened all applicants for Medicaid eligibility. If the family income suggested probable eligibility for Medicaid, the state notified the family in writing that the child could not be insured by the Children's Health Insurance Plan.

The CHIP application form contained a statement that demographic information from the CHIP application was automatically sent to the county public assistance office to begin the Medicaid application process for children who appeared to be Medicaid eligible. (Families could check a box saying that this information could not be forwarded.)*

The demographic information from the CHIP application was forwarded to the appropriate county public assistance office. This Medicaid application form was a common form used by anyone applying for Medicaid. It was not unique to CHIP. The demographic information forwarded was also the same information which would be supplied by any other Montanan wishing to start the application process for Medicaid. It took one or two days for the mail to deliver this application to the appropriate county office.

Upon receipt of this Medicaid application in the county office, the time clock for processing Medicaid eligibility began. The county office contacted the family and set up an in-person interview which is part of Montana's Medicaid eligibility process. The same Medicaid eligibility process and time frames were used for these "CHIP referred" families as for all other eligibility determinations. Medicaid eligibility was routinely determined within 30 days of receipt of the application in the county office.**

When the Medicaid application was forwarded to the county, a CHIP denial letter was sent to the family. This letter told the family: a) that they appeared to be Medicaid eligible and that we forwarded the demographic information to the appropriate county public assistance office to begin the Medicaid application process, b) they would receive a phone call or letter from their county public assistance office to set up an interview to determine Medicaid eligibility, c) they should take the full Medicaid application (which we included with this letter) and the supporting documentation specified on the application to their interview, d) the importance of obtaining health care coverage for children and how Medicaid could assist them, and e) that if they had further questions, they could call the state who would assist them.

*Demographic information includes name, address, phone number, date and place of birth, sex, social security number, marital status, and citizenship.

**Montana examined the feasibility of making the date of CHIP application the date for Medicaid application as well. We rejected this option because we believe that this would compress the time frames that families must respond in and would result in more denials of Medicaid eligibility for the "technical" reason that families failed to provide information required by Medicaid in a timely manner. If that happened, we fear that many families would become frustrated with the process and drop out.

Families who refused permission to forward information to Medicaid

Families could check a box on the CHIP application form saying that CHIP demographic information may not be forwarded to the county public assistance office to begin the Medicaid application process. (They had to pro-actively take this step. Otherwise, the CHIP application form contained a statement that demographic information from the CHIP application was automatically sent to the county public assistance office to begin the Medicaid application process for children who appeared to be Medicaid eligible.)

The CHIP program screened applicants for Medicaid eligibility. If the family income suggested probable eligibility for Medicaid, the state notified the family in writing that the child could not be insured by the Children's Health Insurance Plan. This denial letter stressed the importance of health care coverage and services for children and urged the family to complete and forward the attached Medicaid application to the county public assistance office. The family was informed that they could contact the state if they had further questions.

Families who were determined ineligible for Medicaid

Families who were referred by the CHIP program and who were subsequently determined ineligible for Medicaid by the county public assistance office were sent a letter denying Medicaid eligibility. The family sent this denial notice from Medicaid and their annual enrollment fee to the CHIP eligibility broker and asked that CHIP eligibility be determined. The state had the CHIP application in their files so this did not need to be resubmitted. Enrollment of these children in the CHIP program was subject to available funding.

Caring Program

Children on the Caring Program were allowed to choose to stay with this program or apply for CHIP. The Caring Program is a primary and preventive health care program, not an insurance product.

Native Americans

Presentations on the proposed components of the CHIP package were made to Native Americans in three different forums. These include the Region VIII HCFA Tribal Consultation meeting 11/6/97, the Montana-Wyoming Area Indian Health Board meeting on 11/24/97, and the DPHHS Native American Advisory Council meeting 12/9/97. An overview of the CHIP program was given and people were specifically asked their thoughts on coverage (Medicaid, private insurance, or a combination), components of the benefit package, and cost-sharing. Each audience was asked about their ideas for outreach to Native American populations.

IHS supported CHIP outreach by supplying the CHIP Program with mailing labels for families with children who were on the IHS roles but not eligible for Medicaid so that CHIP could send information and applications to those families.

3.6 How do you avoid crowd-out of private insurance?

3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

X Eligibility determination process:

- X Waiting period without health insurance (specify) 3 months
- X Information on current or previous health insurance gathered on application (specify) - eligibility for state employee health benefits; eligibility for health insurance within 3 months prior to application (limited exceptions apply).
- ___ Information verified with employer (specify)

X__ Records match (specify) - Medicaid
___ Other (specify)
___ Other (specify)

__ Benefit package design:

___ Benefit limits (specify)
___ Cost-sharing (specify)
___ Other (specify)
___ Other (specify)

___ Other policies intended to avoid crowd out (e.g., insurance reform):

___ Other (specify)
___ Other (specify)

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

Not applicable.

FFY 2000 - Monitoring of "crowd out" was initiated. A "CHIP Enrollee Questionnaire was sent to all active CHIP Pilot families in November 1999. Two hundred fifty-seven questionnaires were returned to the CHIP Program by February 16, 2000. The following question was asked: "Were your children ever covered by health insurance before they were covered by CHIP? Do not include coverage by Medicaid, Indian Health Service or the Caring Program." Seventy-eight percent of the respondents indicated they had never been covered by health insurance before they were covered by CHIP.

SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in your CHIP program?

4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

Table 4.1.1a CHIP Program Type State- designed

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	0	1019	0	8.1	0	96
Age						
Under 1	0	14	0	5.6	0	0
1-5	0	214	0	7.9	0	21
6-12	0	484	0	7.9	0	30
13-18	0	307	0	8.6	0	45

Countable Income Level*						
At or below 100% FPL	0	340	0	8.3	0	54
Above 100% FPL	0	679	0	8.0	0	42
Age and Income						
Under 1						
At or below 100% FPL	0	3	0	8.3	0	0
Above 100% FPL	0	11	0	4.8	0	0
1-5						
At or below 100% FPL	0	58	0	8.1	0	11
Above 100% FPL	0	156	0	7.9	0	10
6-12						
At or below 100% FPL	0	156	0	8.0	0	16
Above 100% FPL	0	328	0	7.8	0	14
13-18						
At or below 100% FPL	0	123	0	8.8	0	27
Above 100% FPL	0	184	0	8.5	0	18

Type of plan						
Fee-for-service						
Managed care	0	1019	0	8.1	0	96
PCCM						

Notes: Montana began reporting enrollment data in Quarter 2, FFY 1999; therefore data for FFY 1999 is only partial.
Cost sharing is in effect for enrollees >100% FPL; therefore, 100% FPL is used instead of 150% FPL for this table.
*Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150% FPL. See the HCFA Quarterly Report instructions for further details.

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

Table 4.1.1b CHIP Program Type State- designed

Characteristics	Number of children ever enrolled					
	FFY 1998	FFY 1999 #	FFY 1999 %			
All Children	0	1019	100%			
GENDER						
Male	0	529	52%			
Female	0	490	48%			
RACE						
White	0	815	80%			
Black	0	5	.5%			
Am Indian	0	136	13.3%			

Alaskan Native						
Hispanic	0	38	3.7%			
Asian/Pacific Islander	0	4	.4%			
Other	0	21	2.1%			
Ethnicity	0	NA	NA			
Employment Status						
1 Parent	0	689	67.6%			
2 Parents	0	258	25.3%			
Neither	0	72	7.1%			
Parental Marital Status	0	NA	NA			
Urban/Rural	0	NA	NA			
Immigrant Status	0	2	.02%			

Characteristics of families and children enrolled in the CHIP Pilot Program

As indicated in the above tables (4.1.1a and 4.1.1b), one-third (33.3%) of the children were from families whose incomes were at or below

100% FPL and two-thirds (66.6%) of the children were between 100 and 150% FPL. The average number of months of enrollment was 8.1 months. The percent of disenrollees was 9.4%. Hence, the percent of year-end enrollees compared to unduplicated enrollees in FFY 1999 was 88.6%.

There were slightly more males (52%) than females (48%). The majority of the children were White (80%) with the second most predominant group being American Indian/Alaskan Native (13.3%). The overwhelming majority had one parent (67.6%) or both parents (25.3%) who were employed. There were extremely few immigrant children (.02%).

4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

Prior to the Pilot CHIP initial enrollment (January 1, 1999) letters and applications were sent encouraging families to apply for CHIP. The targeted groups were: Indian Health Service clients (non-Medicaid), former TANF families who had their benefits (e.g. Medicaid) discontinued within the previous 6 months, clients with Mental Health Access Plan or Children with Special Health Care Needs coverage and families on the waiting list for the Caring Program.

CHIP applicants with private health insurance coverage within the previous three months (limited exceptions applied), eligibility for state employee health benefits or current Medicaid coverage were ineligible for CHIP.

FFY 2000 - a "CHIP Enrollee Questionnaire" was sent to all active CHIP Pilot families in November 1999. Two hundred fifty-seven questionnaires were returned to the CHIP Program by February 16, 2000. The following question was asked: "Were your children ever covered by health insurance before they were covered by CHIP? (Do not include coverage by Medicaid, Indian Health Service or the Caring Program.)" Seventy-eight percent (78%) of the respondents indicated they had never been covered by health insurance before they were covered by CHIP.

FFY 2000 - The CHIP data system will be tracking and reporting data on access to or coverage by health insurance at the time or application and disenrollment.

4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))

Not applicable – there are no other public or private programs.

4.2 Who disenrolled from your CHIP program and why?

4.2.1 How many children disenrolled from your CHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

The number of children who disenrolled was 96 out of 1,019; the disenrollement rate was 9.4%. This rate was higher than the 2% that we expected. The Medicaid disenrollment rate for FFY 1999 is not available at this time.

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP?

Our CHIP Pilot was providing benefits for only nine months of FFY 1999 and families were not scheduled to renew during this time period; renewal was not until January 1, 2000.

<u>FFY 2000</u> - In mid-November 1999 applications and questionnaires were sent to all active CHIP Pilot families. Two hundred fifty-seven questionnaires were returned to the CHIP Program by February 16, 2000. Only three of the respondents indicated that they were not reapplying. The reasons given were: that "our income was above the income guidelines", "my husband started a new job and will be getting insurance through the company January 1st" and "they are 18 years old right now".

<u>FFY 2000</u> - Families who did not reapply for CHIP by January 1, 2000 were sent a postcard urging them to reapply and reminding them that benefits were discontinued effective December 31, 1999. CHIP staff members telephoned those families who did not respond to the postcard. Thirteen of the 82 respondents contacted indicated that they were not reapplying for CHIP. The reasons given were that they either had or were applying for private insurance (62%) or Medicaid (23%); were over income (15%), and their child was now over age 19 (<1%).

4.2.3 What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)

Table 4.2.3

Reason for discontinuation of coverage	Medicaid CHIP Expansion Program		State-designed CHIP Program		Other CHIP Program* _____	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
Total			96	100		
Access to commercial insurance			17	17.7		
Eligible for Medicaid			57	59.3		
Income too high						
Aged out of program			11	11		
Moved/died			11 (10/1)	11		
Nonpayment of premium						
Incomplete documentation						
Did not reply/unable to contact						
Other (specify)						
Other (specify)						

Don’t know						

Reasons for disenrollment during the reporting period (FFY 1999) – the sources for this information were the CHIP data system, the state data system (MMIS), notification by families and the insurance plan, returned mail, and surveys completed by families in FFY 2000.

4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

Not applicable - all of the children who disenrolled from CHIP during the Pilot were no longer eligible for CHIP.

FFY 2000 - we plan to contact each family who disenrolls if it is unclear if they may still eligible for CHIP. We will encourage those families who are still eligible to re-enroll in CHIP.

4.3 How much did you spend on your CHIP program?

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 _____0_____

FFY 1999 ____$747,228_____

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

Table 4.3.1 CHIP Program Type State-designed

Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures	0	$747,228	0	$599,351
Premiums for private health insurance (net of cost-sharing offsets)*	0	$672,505	0	$539,416

Fee-for-service expenditures (subtotal)	0	$74,723	0	$59,935
Inpatient hospital services				
Inpatient mental health facility services				
Nursing care services				
Physician and surgical services				
Outpatient hospital services				
Outpatient mental health facility services				
Prescribed drugs				
Dental services				
Vision services				
Other practitioners' services				
Clinic services				
Therapy and rehabilitation services				
Laboratory and radiological services				
Durable and disposable medical equipment				
Family planning				
Abortions				
Screening services				
Home health				

Home and community-based services				
Hospice				
Medical transportation				
Case management				
Other services				

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

What types of activities were funded under the 10 percent cap?

What role did the 10 percent cap have in program design?

The 10% cap was a significant hindrance to the development, establishment and outreach efforts of our CHIP Program during FFY 99. During this "start-up" year there was a considerable amount of administrative expenses incurred prior to the time children were enrolled and began to receive benefits.

Some of those expenses included: writing job descriptions, hiring & training staff, ordering & set up of equipment, establishing an office, etc. Developing and modifying computer systems (CHIP interim enrollment database, TESS, MMIS, TEAMS), writing and producing CHIP applications and informational materials, developing and negotiating the contract with insurance plan, developing and monitoring the contracts with the Department's fiscal agent and insurance plan, etc.

FFY 2000 - writing administrative rules, developing marketing materials, developing and monitoring contract for outreach services with the Montana Covering Kids Project (Robert Wood Johnson Foundation grant and Medicaid administrative matching funds).

Table 4.3.2

Type of expenditure	Medicaid Chip Expansion Program		State-designed CHIP Program		Other CHIP Program* _____	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share			0	$147,877		
Outreach						
Administration				$ 14,788		

Other - Benefits				$133,089		
Federal share						
Outreach						
Administration						
Other _____						

Note: Outreach and administrative expenditures were not tracked separately since the HCFA quarterly report requests a combined total.

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))

___ State appropriations
___ County/local funds
___ Employer contributions
___ Foundation grants
__ Private donations (such as United Way, sponsorship)
X_ Other (specify) Initially, the CHIP Pilot was funded with a $210,000 intergovernmental transfer from the Office of the Commissioner of Insurance. In April 1999 the Montana Legislature appropriated the state match to be funded by a portion of Montana's share of the multi-state Tobacco Settlement.

4.4 How are you assuring CHIP enrollees have access to care?

4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees?

Table 4.4.1			
Approaches to monitoring access	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Appointment audits			

PCP/enrollee ratios			
Time/distance standards			
Urgent/routine care access standards			
Network capacity reviews (rural providers, safety net providers, specialty mix)			
Complaint/grievance/ disenrollment reviews		X	
Case file reviews			
Beneficiary surveys			
Utilization analysis (emergency room use, preventive care use)			
Other (specify) _____			
Other (specify) _____			
Other (specify) _____			

FFY 2000 – CHIP will continue disenrollment reviews. We are instituting complaint/grievance reviews, monitoring of 24 hour access to care and collecting HEDIS measures which include "children's access to primary care".

4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.

Not applicable

Table 4.4.2			
Type of utilization data	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____

Requiring submission of raw encounter data by health plans	___ Yes ___ No	X Yes ___ No	___ Yes ___ No
Requiring submission of aggregate HEDIS data by health plans	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No
Other (specify)_____	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No

4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

There was a total of 954 providers throughout Montana (719 physicians, 41 hospitals and 194 allied providers). Each of our 56 counties had at least one CHIP provider. There were 1,019 children enrolled during the Pilot and there were no complaints by families about lack of access to CHIP providers.

4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

FFY 2000 – CHIP will continue disenrollment reviews. We are instituting complaint/grievance reviews, monitoring of 24 hour access to care and collecting HEDIS measures which include "children's access to primary care".

4.5 How are you measuring the quality of care received by CHIP enrollees?

4.5.1 What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations?

Data not yet available.

FFY 2000 – We are conducting a client satisfaction survey, instituting complaint and grievance policies, monitoring HEDIS measures and the following performance measurements (establishing baseline measures in FFY 2000 and performance goals of 5% over baselines for FFY 2001):

- *enrolled children under 2 years of age who receive the basic immunization series*
- *enrolled 13 year olds who receive required immunizations*

- *enrolled children under 15 months who receive the recommended number of well-child visits*
- *enrolled 3,4,5 and 6 year old children who receive at least one well-child visit during the year*
- *enrolled children 12-17 years old who receive at least one well-care visit during the year.*

Table 4.5.1			
Approaches to monitoring quality	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program
Focused studies (specify)			
Client satisfaction surveys			
Complaint/grievance/ disenrollment reviews		MCO - indemnity insurance	
Sentinel event reviews			
Plan site visits			
Case file reviews			
Independent peer review			
HEDIS performance measurement			
Other performance measurement (specify)			
Other (specify) _____			
Other (specify) _____			
Other (specify) _____			

4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

Not available at this time.

4.5.3 What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?

Availability:

- Summer 2000 - Complaint and Grievance data
- Spring 2000 - Client Satisfaction Survey results
- Summer 2001 - HEDIS and Performance Measures (HEDIS is measured on a calendar year basis and 1999 will be the first full calendar year available)

4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please list attachments here.

Attachments include: Addendum to Table 3.1.1

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)

5.1.1 Eligibility Determination/Redetermination and Enrollment

See responses in Section 3.1.

Our CHIP Pilot had children enrolled for only nine months of FFY 1999 (January 1 – September 30, 1999). Therefore, redetermination/re-enrollment was not done during this time period.

5.1.2 Outreach

In FFY 1998 and FFY 1999 to ensure that we obtained support, the state held numerous discussions and meetings with key stakeholders in Montana. The primary means we used are outlined below:

CHIP Advisory Committee:
The Department of Public Health and Human Services (DPHHS) hosted a preliminary meeting on 7/31/97 to discuss a planning strategy for the CHIP program with children's advocacy groups, the Governor's budget staff, Title X, Medicaid, and health insurers. DPHHS then formed a broad-based Children's Health Insurance Advisory Committee to develop the plan for implementing the block grant. The Advisory Committee includes representatives from the Governor's office, DPHHS (Title X, Title V, Medicaid Part C, TANF), State Insurance Commissioner's Office, Office of Public Instruction, members of the State Legislature, children's advocacy groups, families, schools, clergy, business, insurance, health care providers, Native Americans, and others. The Advisory Council met four times (9/22/97, 10/20/97, 1/27/98, and 3/31/98). The meetings were open to the public. They were advertised in the newspapers and on the Department bulletin board and were well-attended (80 to 130 people in attendance at each meeting). The last two meetings used the state's interactive video technology; people from eight different communities were able to participate.

Basic design of CHIP including using Medicaid, private insurance, or a combination for coverage; insurance benefit design; and cost-sharing options were discussed thoroughly. All comments and suggestions were given serious consideration in developing the state plan. The "draft" state plan itself was the topic of the 3/31/98 meeting.

Public Forums:
In late November and early December of 1997, public forums were held in Miles City, Billings, Great Falls, Missoula, Kalispell, and Bozeman to gather public opinion about the design of the CHIP program. Invitations were sent to more than 1,020 people/organizations (including Head Starts, tribal chairs, county public assistance directors, legislators, county commissioners, Human Resource Development Councils, family preservation groups, the DPHHS Native American Advisory Council, Medicaid Primary Care Providers, provider and consumer associations, Montana Health Care Coalition, Montana Health Care Advisory

Council and low income advocacy groups).

The forums were held in the evening to ensure maximum participation. More than 120 people attended the forums. Fifty of those attending signed in as citizens, taxpayers, or members of low income advocacy coalitions. An overview of the program was given and people were specifically asked their thoughts on coverage (Medicaid, private insurance, or a combination), components of the benefit package, and cost-sharing.

Native Americans:
Presentations on the proposed components of the CHIP package were made to Native Americans in three different forums. These include the Region VIII HCFA Tribal Consultation meeting 11/6/97, the Montana-Wyoming Area Indian Health Board meeting on 11/24/97, and the DPHHS Native American Advisory Council meeting 12/9/97. Again, an overview of the program was given and people were specifically asked their thoughts on coverage (Medicaid, private insurance, or a combination), components of the benefit package, and cost-sharing. Each audience was asked about their ideas for outreach to Native American populations.

Legislative Input:
The Department made presentations at ten interim committee meetings on the CHIP program between October 1997 and March 1998. These included the Legislative Finance Committee, the Oversight Committee on Children and Families, and the Committee on Indian Affairs. In addition, all legislators received three newsletters containing CHIP program development updates and an invitation to attend the public forums. Four key legislators serve on the CHIP Advisory Council.

Numerous presentations were made to Legislative Committees during the biannual session that met January through April of 1999. The Legislature created CHIP with Senate Bill 81. The CHIP legislation received broad bipartisan support.

Meetings With Interested Parties:
CHIP staff have given more than ninety presentations to other interested parties. Some of the groups we met with are: Montana Hospital Association, Montana Health Coalition, Health Advisory Council, statewide Public Health Association conference, Family Planning State Council, Montana Council for Maternal and Child Health, Montana Children's Alliance, Children's Committee of the Mental Health Association, Head Start, statewide meeting of Public Health and School Nurses, Governor's Council on Children and Families, the Montana Association of Counties Human Services Committee, Montana People's Action, Working for Equality and Economic Liberation, Montana Covering Kids, and the Native American Advisory Council. At the request of several of these organizations, a CHIP update is done at each meeting, allowing time for questions, comments, and problem-solving.

Since the implementation of CHIP, DPHHS advisory councils already in place have provided important advice, comments, and recommendations to CHIP. CHIP staff sit on the advisory council for Montana Covering Kids Project.

There was a cap on the number of children who could be enrolled in FFY 1999 because of limited state funding for the CHIP Pilot. As a result of the initial outreach efforts to the targeted groups (Indian Health Service clients (non-Medicaid), former TANF families who had their benefits (e.g. Medicaid) discontinued within the previous 6 months, clients with Mental Health Access Plan (MHAP) coverage and families on the waiting list for the Caring Program, that cap was met very early in the Pilot. There were no subsequent outreach efforts since we were unable to provide health coverage to additional children until FFY 2000.

5.1.3 Benefit Structure

In developing the benefit structure there is an ongoing debate about whether to provide a more comprehensive package of benefits for fewer children or a less comprehensive package for more children. We continue to strive to find the balance for Montana's children.

In order to support enrollees' extracurricular and employment activities, the CHIP Program provides coverage for athletic and employment physical examinations.

During the CHIP Pilot we did not have coverage for dental services and eyeglasses. These are covered benefits for FFY 2000 and paid for by DPHHS, not the insurance plan.

Although contraceptives were a covered benefit in the CHIP Pilot, the Montana Legislature discontinued them as a covered benefit for FFY 2000.

5.1.4 Cost-Sharing (such as premiums, co-payments, compliance with 5% cap)

Montana does not agree with the HCFA interpretation of section 2103(e)(3) or the refusal to extend the table cited as an example in 42 CFR 447.52(b). We would point out that this table was established in 1978 and has never been updated. The federal poverty level for a family of three in 1998 is $1137.50/month and for a family of five is $1604.17/month, yet the table stops at $1000/month. Failure to extend this table results in families with less income being charged a proportionately greater share than

families with more income.

With great reluctance we amended our cost sharing plan to the following:

Annual Enrollment Fee

- No annual enrollment fee is assessed for families below 100% of the federal poverty level.
- A $12 annual enrollment fee is charged for a family of one who is at or above 100% of the federal poverty level. This applies only in the case of an emancipated minor, since all families with a parent present will have at least two members.
- A $15 annual enrollment fee is charged for families of two or more who are at or above 100% of the federal poverty level.

Co-payment

- No co-payment is assessed for families below 100% of the federal poverty level.
- For families at or above 100% of the federal poverty level, the following co-payments applies:
  -Inpatient hospital services (includes hospitalization for physical, mental and substance abuse reasons) $25/admission
  -Emergency room visit $ 5/visit
  -Outpatient hospital visit (includes outpatient treatment for physical, mental, and substance abuse reasons - excludes outpatient visit for x-ray or laboratory services only) $ 5/visit
  -Physician, mid-level practitioner, optometrist audiologist, mental health professional, or substance abuse counselor services (excludes pathologist, radiologist, or anesthesiologist services) $ 3/visit
  -Outpatient prescription drugs $3/prescription generic drug
  $ 5/prescription for brand-name drug
- No co-payment applies to well-baby or well-child care, including age-appropriate immunizations.

- Co-payment is capped at $200/family/year. This is 2.5% of the family income for a family of one and 1% of the family income for a family of five at 100% of the federal poverty level. Co-payment is tracked by the insurance company and communicated to the family with their statement of benefits paid.

5.1.5 Delivery System

We had intended to have both indemnity insurance and managed care available to children in the CHIP Pilot Program. However, there were no managed care organizations that were interested in participating. We had one insurance plan, Blue Cross Blue Shield, participate in the Pilot Program and hope to expand to other insurance partners in FFY 2000.

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)

Since our eligibility criteria is $\leq$ 150% FPL there were very few families who had access to private or employee-based health coverage. Therefore, "crowd-out" was not as much of an issue as it may have been in other states with a higher eligibility criteria.

FFY 2000 - Monitoring of "crowd out" was initiated. A "CHIP Enrollee Questionnaire was sent to all active CHIP Pilot families in November 1999. Two hundred fifty-seven questionnaires were returned to the CHIP Program by February 16, 2000. The following question was asked: "Were your children ever covered by health insurance before they were covered by CHIP? Do not include coverage by Medicaid, Indian Health Service or the Caring Program." Seventy-eight percent of the respondents indicated they had never been covered by health insurance before they were covered by CHIP.

FFY 2000 – Our data system will be able to track and report the number and percentage of families who have insurance at the time of application and disenrollment.

5.1.7 Evaluation and Monitoring (including data reporting)

The time required to comply with the evaluation, monitoring and data reporting requirements is extremely expensive for a small program such as Montana's. Administrative dollars and staff time would be better spent on outreach and program improvement.

We suggest a two-tiered approach with more stringent reporting for states with over 20,000 enrollees and less stringent for those states under this limit.

5.1.8 Other (specify)

Legislation for our CHIP Program was sponsored by the Senate Majority Leader, had extensive bipartisan support as well as the support of the governor. The legislature voted to fund the state portion of the program with funds from the multi-state Tobacco Settlement.

5.2 What plans does your State have for "improving the availability of health insurance and health care for children"? (Section 2108(b)(1)(F))

Montana's legislature meets every two years and the department has not yet finalized our budget recommendations to the Governor. Plans for improving the availability of health insurance and health care for Montana children are under discussion at this time. We will notify HCFA of any change that would affect our State Plan.

5.3 What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

The following recommendations are in response to the CHIP rules recently proposed by HCFA and published in the Federal Register on 11/8/99:

Montana agrees that Indian children are under served by the federal Indian Health Services program. Montana proposes that the federal government provide 100% funding for services at an Indian Health Services facility to states that wish to provide enhanced reimbursement to these facilities. We w further propose that the federal government provide states with 100% federal funding to replace the lost revenue from not being able to impose cost-sharing provisions on Indian children. (This prohibition on cost-sharing is a clear departure from the current Medicaid program. Under Medicaid, states are allowed to impose cost-sharing provisions on Indian people even though Indian Health Service facilities cannot impose cost-sharing themselves.) The provision of enhanced federal funding would both help assure that Indian children receive needed services and protect states with a large Indian population from assuming a disproportionate share of the federal responsibility to provide health care to Indian children.

Additionally, Montana requests confirmation in the proposed rules that states have the option of allowing Indian people self-declare the AI/AN status of their children, rather than requiring documentation at the time of eligibility determination.

Targeted Low-Income Child

Montana believes that when a state or public agency makes only a nominal contribution toward health coverage for dependent children, there is often no "real" benefit available to the child. We recommend, however, that the use of a percentage of the premium paid by the state/public agency is a fairer assessment of what constitutes a "nominal" contribution. Nominal might be defined as when the state contributes less than 35 to 40% of the premium for dependant children. Setting a percentage of premium payment, rather than a flat dollar amount, allows for an automatic adjustment for inflation in the coming years. We note that HCFA uses percentages in both the cost-sharing provisions and the premium assistance for employer-sponsored plans in the proposed rules.

We urge HCFA to reconsider the proposed rule to exclude children in an IMD at the time of eligibility redetermination. It seems blatantly unfair that a child be denied CHIP coverage simply because they are residing in an IMD when their redetermination period is due. As HCFA points out in the rationale, this results in children receiving inequitable benefits.

Other Eligibility Standards

HCFA proposes that a state may not require a social security number of an applicant child or family member be provided as a condition of eligibility. This seems to be at odds with other proposed requirements that we both verify that the child is not on Medicaid and that we have a fraud and abuse system in place. The social security number is the easiest and most accurate way to verify income and Medicaid eligibility. States do need further clarification of whether they can require provision of a social security number when a joint application for CHIP and Medicaid is used.

Premiums, Enrollment Fees, or Similar Fees: State Plan Requirements

Montana vehemently opposes any attempt by HCFA to amend the CHIP statute to include in the cost-sharing limits services not covered by the CHIP program for children with chronic conditions. HCFA has already made cost-sharing administratively burdensome, confusing and expensive through their narrow interpretations of the enabling CHIP statutes. Expansion of the cost-sharing limits to an undefined group of "chronically-ill" children for services not even paid for by the CHIP program is unworkable. States were given the option of choosing a state-only program under the CHIP enabling legislation. States, such as Montana, who chose this option do not wish to create an entitlement to service. If we wanted to create an entitlement, we would have chosen the Medicaid option. We chose our CHIP coverage plan after extensive public input from Montanans to serve the greatest number of children with a reasonable benefit package and to ensure that families shared in the ownership of the program through cost-sharing provisions.

The suggested tracking mechanisms are administratively burdensome and expensive given that co-payments are capped at amounts between $1 and $5. (How can a state issue a credit card, pay providers, and bill beneficiaries to collect $1, or even $5 and come out even? A swipe card is equally cost-prohibitive.)

Cost Sharing for Well-Baby and Well-Child Care

Montana opposes the inclusion of laboratory tests and routine preventive and diagnostic dental benefits in the prohibition of cost sharing for well-baby and well-child care. HCFA makes the argument that these are preventive or diagnostic in nature. So is mental health screening, evaluation by a physical therapist, and a variety of other services. The inclusion of dental and laboratory goes beyond what the CHIP statute envisioned.

Cost Sharing Charges for Children in Families At or Below 150 Percent of the Federal Poverty Level

The vast majority of cost-sharing provisions and limits in the Medicaid program have not been updated to reflect inflation since the 1970's. These include the enrollment fees, premiums and similar charges. This is one reason that we believe that the use of percentages rather than set dollar amounts is more appropriate whenever feasible. We prefer that HCFA either set percentages or update dollar amounts for inflation if Medicaid limits are incorporated into the CHIP program. HCFA proposes that total cost-sharing be limited to 2.5% of a family's income for a year (or 12 month eligibility period.) We propose that this limit be raised to 5% as was specified in the statute for families with incomes over 150% of poverty. When the amount is set as a percentage of income, there is no need to make the percentage less.

It is important that states retain the flexibility to define the year for purposes of cost-sharing as the insurance benefit year for group insurance rather than an individual family eligibility period as HCFA proposed. Commercial indemnity insurance tracks cost-sharing requirements on a benefit year basis when group insurance is purchased. To use individual family eligibility periods would be an administrative nightmare. Using the group plan benefit year would be consistent with Medicaid. Montana has used the state benefit year for our Medicaid population for determining cost-sharing since the 1980's.

Restriction on the Frequency of Cost Sharing Charges on Targeted Low-Income Children in Families At or Below 150 Percent of the FPL

Montana opposes the prohibition on imposing more than one cost-sharing charge for multiple services provided during a single office visit. Cost-sharing, to be meaningful, should relate to the provision of services rather than a visit. Otherwise, there is no incentive to be a cost-conscious educated consumer. Under the system HCFA is proposing, a "visit" costs the beneficiary the same amount in cost-sharing whether you receive one or twenty services. This is not the way that cost-sharing provisions are applied in either Medicaid or private insurance. The CPT-IV codes for physicians do not bundle multiple physicians or multiple services into a single visit. The proposed rule is also more restrictive than the current Medicaid provisions which tie cost-sharing to services, not visits. The proposal is also patently inequitable to the CHIP beneficiary. It favors (in terms of cost-sharing) the beneficiary who receives multiple services on the same day over the beneficiary who receives services over a longer time period. This added restraint on cost-sharing is unnecessary because CHIP beneficiaries are already protected by the overall cost-sharing caps and the limits on co-payments from excessive charges.

Disenrollment Protections

We oppose the proposed rules to require specific time frames and grace periods before a family can be disenrolled from a program for nonpayment of premiums or other cost-sharing mechanisms. This is an area best left to state discretion.

The rule as proposed requires states to track grace periods before a family is disenrolled from the CHIP program. Why would a family ever pay their share of the premium if they could claim hardship and have the state pick up the bill in its entirety? We don't think enough credit is being given to the CHIP families. They receive notice of other bills and pay them. There is no reason to believe that they will not pay for insurance if it is important to them.

Administratively, this can be very expensive to collect the very limited amounts of cost-sharing that can be assessed.

If a time period is absolutely necessary, we would suggest 30 days. Again, we believe that this should be at state discretion rather than in the HCFA rules.

Annual Report

The proposed expansion of the annual report to include progress on meeting strategic objectives and performance goals, successes in program design, planning, and implementation of the State plan, identifying barrier and approaches to overcome barriers is unnecessary and administratively burdensome. This is information that would be better collected on an every three to five year basis when states have some track record with the program. It would also be better collected as a HCFA best practices survey rather than in the format proposed. It appears that HCFA has gone well beyond what Congress required in the enabling legislation in drafting this language.

Fraud Detection and Investigation

Montana objects to the requirement that states must meet the Medicaid goals for fraud detection and investigation. We would have preferred that HCFA allow the states full discretion to design processes and procedures to meet the needs of our CHIP program. Medicaid regulations are overly restrictive and administratively expensive for small state-only programs to administer. In essence we must bring up the same program for the 10,000 children we will be serving under CHIP as we maintain for 120,000 Medicaid recipients. In our state there has been very little provider or recipient abuse, especially in the area of children's services, in the Medicaid program. There is really no reason to believe that the CHIP program will have a different experience. Adding yet another administrative duty has a direct impact on our ability to perform CHIP outreach and enrollment activities because of the 10% administrative cap we are subject to as a state-only program.

If HCFA retains this requirement, we recommend a tiered system for small CHIP populations versus large programs. The other area that would be of assistance to states would be to let CHIP programs buy a portion of an FTE from SURS and fraud units. This would require a change in the current regulation that requires that these personnel be employed solely with Medicaid funds.

Addendum to Table 3.1.1

The following questions and tables are designed to assist states in reporting countable income levels for their Medicaid and SCHIP programs and included in the NASHP SCHIP Evaluation Framework (Table 3.1.1). This technical assistance document is intended to help states present this extremely complex information in a structured format.

The questions below ask for countable income levels for your Title XXI programs (Medicaid SCHIP expansion and State-designed SCHIP program), as well as for the Title XIX child poverty-related groups. Please report your eligibility criteria as of **September 30, 1999.** Also, if the rules are the same for each program, we ask that you enter duplicate information in each column to facilitate analysis across states and across programs.

If you have not completed the Medicaid (Title XIX) portion for the following information and have passed it along to Medicaid, please check here **9** and indicate who you passed it along to. Name_____, phone/email_____

3.1.1.1 For each program, do you use a gross income test or a net income test or both?

Title XIX Child Poverty-related Groups __X_Gross ____Net ____Both

Title XXI Medicaid SCHIP Expansion ____Gross ____Net ____Both

Title XXI State-Designed SCHIP Program __X_Gross ____Net ____Both

Other SCHIP program_____ ____Gross ____Net ____Both

3.1.1.2 What was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately.

Title XIX Child Poverty-related Groups 133 % of FPL for children under age 6_____

100 % of FPL for children aged 6 or born on or after10/1/83

	40.5 % of FPL for children aged born before 10/1/83
Title XXI Medicaid SCHIP Expansion	____% of FPL for children aged _____
	____% of FPL for children aged _____
	____% of FPL for children aged _____
Title XXI State-Designed SCHIP Program	150 % of FPL for children aged 0-18
	____% of FPL for children aged _____
	____% of FPL for children aged _____
Other SCHIP program_____	____% of FPL for children aged _____
	____% of FPL for children aged _____
	____% of FPL for children aged _____

3.1.1.3 Complete Table 1.1.1.3 to show whose income you count when determining eligibility for each program and which household members are counted when determining eligibility? (In households with multiple family units, refer to unit with applicant child)

Enter "Y" for yes, "N" for no, or "D" if it depends on the individual circumstances of the case.

Table 3.1.1.3

Family Composition	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Child, siblings, and legally responsible adults living in the household	Y		Y	
All relatives living in the household	N		N	
All individuals living in the household	N		N	
Other (specify)			Siblings age 19-	

			21 who are attending an institute of higher learning are counted in family size but their income is not counted.	

3.1.1.4 How do you define countable income? For each type of income please indicate whether it is counted, not counted or not recorded. ***Enter "C" for counted, "NC" for not counted and "NR" for not recorded.***

Table 3.1.1.4				
Type of Income	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Earnings				
Earnings of dependent children	NC		NC	
Earnings of students	NC		NC	
Earnings from job placement programs	C		C	
Earnings from community service programs under Title I of the National and Community Service Act of 1990 (e.g., Serve America)	NC		NC	
Earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g., AmeriCorps, Vista)	NC		NC	
Education Related Income Income from college work-study programs	NC		NC	
Assistance from programs administered by the Department of Education	NC		NC	
Education loans and awards	NC		NC	

Other Income Earned income tax credit (EITC)	NC		NC	
Alimony payments received	C		C	
Child support payments received	C		C	
Roomer/boarder income	C		C	
Income from individual development accounts	NC		NC	
Gifts	NC		NC *	
In-kind income	C		NC	
Program Benefits Welfare cash benefits (TANF)	NC		NC	
Supplemental Security Income (SSI) cash benefits	NC		NC	
Social Security cash benefits	C		C	
Housing subsidies	NC		NC	
Foster care cash benefits	NC		NC	
Adoption assistance cash benefits	NC		NC	
Veterans benefits	C		C	
Emergency or disaster relief benefits	NC		NC	
Low income energy assistance payments	NC		NC	
Native American tribal benefits	NC		NC	
Other Types of Income (specify)				

* Gifts are counted if they are received on a regular basis.

3.1.1.5 What types and *amounts* of disregards and deductions does each program use to arrive at total countable income?

Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA."

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____ Yes _X_ No

If yes, please report rules for applicants (initial enrollment).

Table 3.1.1.5

Type of Disregard/Deduction	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Earnings	$ NA	$	$ NA	$
Self-employment expenses	$ NA	$	$ NA	$
Alimony payments Received	$ NA	$	$ NA	$
Paid	$ NA	$	$ NA	$
Child support payments Received	$ NA	$	$ NA	$
Paid	$ NA	$	$ NA	$
Child care expenses	$ NA	$	$ NA	$
Medical care expenses	$ NA	$	$ NA	$
Gifts	$ NA	$	$ NA	$
Other types of disregards/deductions (specify)	$ NA	$	$ NA	$

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.1.6 For each program, do you use an asset or resource test?

Title XIX Poverty-related Groups	____No	_X_ Yes (complete column A in 3.1.1.7)
Title XXI SCHIP Expansion program	____No	____Yes (complete column B in 3.1.1.7)
Title XXI State-Designed SCHIP program	_X_ No	____Yes (complete column C in 3.1.1.7)
Other SCHIP program_____	____No	____Yes (complete column D in 3.1.1.7)

3.1.1.7 How do you treat assets/resources?

Please indicate the countable or allowable level for the asset/resource test for each program and describe the disregard for vehicles. If not applicable, enter "NA."

Table 3.1.1.7 Treatment of Assets/Resources	Title XIX Child Poverty-related Groups (A)	Title XXI Medicaid SCHIP Expansion (B)	Tit des
Countable or allowable level of asset/resource test	$3,000/HOUSE-HOLD	$	$ N
Treatment of vehicles: Are one or more vehicles disregarded? *Yes or No*	YES - ONE VEHICLE		N
What is the value of the disregard for vehicles?	NO CAP ON VEHICLE VALUE	$	$ N
When the value exceeds the limit, is the child ineligible("I") or is the excess applied ("A") to the threshold allowable amount for other assets? *(Enter I or A)*	**I**		I

3.1.1.8 Have any of the eligibility rules changed since September 30, 1999? ___ Yes

_X_ No